

No. 300
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED OCT 26 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32368

Registration District No. 22

Primary Registration District No. 5289

Registrar's No. 91

1. PLACE OF DEATH:
(a) County Clay *Callatein Township*
(b) City or town Foxwood Addition North K.C.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4817 Sunset Drive Foxwood Add. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Home (Specify whether
In this community 3 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Clay 24
(c) City or town Foxwood Addition North K.C.
(If outside city or town limits, write "RURAL")
(d) Street No. 4817 Sunset Drive 30
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country XXXX

3: (a) PRINT FULL NAME Julius P. Nichols
3. (b) If veteran, name war No 3. (c) Social Security No. 511-20-3402

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug. day 28
year 1948 hour 8 minute 00 A.M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ann Nichols
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased Feb 19 1893
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Coroner Case 19____
that I last saw h_____ alive on _____, 19____
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
55 6 9 XX hr. XX min.

Immediate cause of death Cancer Duration _____
Due to _____
Due to _____

9. Birthplace Weymore Nebraska
(City, town, or county) (State or foreign country)

Other conditions Coroner Case
(Include pregnancy within 3 months of death)

10. Usual occupation Salesman

Major findings: Of operations Coroner Case

11. Industry or business Rusco Storm Window Co

Of autopsy _____
ADDITIONAL INFORMATION REQUESTED

12. Name Joseph R. Nichols 9
13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Johanna Pank
15. Birthplace Beardstown Illinois
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence Coroner Case
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home (Specify type of place) 3

16. (a) Informant Mrs Ann Nichols
(b) Address 4817 Sunset Drive Foxwood Add

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Kelly Bill J. Astor 10/29/48

17. (a) Removal (b) Date thereof: Aug. 30, 48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Enid Oklahoma

Address Liberty, Mo Date signed 9-29-48

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER, FATHER

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 10-15-48

STOBI ET ADM

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Theron O. Smith
working under my personal supervision.

Registered Apprentice No. XY7

Signed Theron O. Smith

Licensed Embalmer No. 3928

P. O. Address. North Lucas City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. NovRegistrar's No. 91Registration District No. 72Primary Registration District No. 5289

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME

Julius P. Nichols

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m5. Color or race W6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Feb 19

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace _____

(City, town, or county)

(State or foreign country) net

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar)

(b) _____

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; to _____, 19____;

that I last saw him _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations Cancer of the Penis+ Colon

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(1) Means of injury _____

23. Signature Robert Magistrate (M.D. or other)Address Liberty Mo Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-32368